

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08773

Reg. Dist. No.

8786

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>8911 Sudbury Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>Louis</u> <u>Alf</u>		4. DATE OF DEATH Month Day Year <u>8</u> <u>9</u> <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1877</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U S A - Major</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Appleton, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ernest Alf</u>		14. MOTHER'S MAIDEN NAME <u>Otilde Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Spanish Amer.</u>		16. SOCIAL SECURITY NO. <u>315-12-4332</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral concussion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by car while walking along side of road</u>	
20c. TIME OF INJURY Month, Day, Year Hour p. m. <u>8-8</u> <u>19 56</u>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Highway</u>	
20f. (City or town) (County) (State) <u>Ocean City</u> _____ <u>Maryland</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>8-9-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal.

STATE OF ALABAMA - JUNE 18, 1956
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

AUG 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **8774**
332

8787

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Anderson</u> Last <u>IV</u>				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>19 56</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 23, 1895</u>		9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Pumps</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Anderson III</u>				14. MOTHER'S MAIDEN NAME <u>G. Ella Mitchell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>215-26-7371</u>		17. INFORMANT Address <u>Mrs. Bernice T. Anderson Quantico, Md.</u>					
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Earl L. Royer</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>8-9-56</u>				
22a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>			22b. DATE THEREOF <u>8/10/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Philips Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Quantico, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Taylor</u>					ADDRESS <u>Salisbury, Maryland</u>				
24a. REC'D BY REGISTRAR <u>8-13-56</u>			24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATEMENT OF MEDICAL EXAMINER
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8788

CERTIFICATE OF DEATH

88775

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 408 Decatur St.			
3. NAME OF DECEASED (Type or print) First OLIVER Middle CHARLES Last BAILEY				4. DATE OF DEATH Month 8 Day 14 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1904		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 10 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing		10b. KIND OF BUSINESS OR INDUSTRY Oyster-Fish		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Bailey				14. MOTHER'S MAIDEN NAME Lucy Hopkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Louise B. Bailey		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombi (tumor cells) 163X DUE TO Metastatic OA in iliac vein Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Lung (c) 						INTERVAL BETWEEN ONSET AND DEATH middle ? 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 14, 1956 to Aug 14, 1956 , that I last saw the deceased alive on Aug 14, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Gray M.D.				ADDRESS (Street, city or town, state) 334 Camden Ave. Salisbury, Md. DATE SIGNED 8/16/56			
PHYSICIAN'S NAME (Type) William D. Gray				334 Camden Ave., Salisbury, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 8/17/1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Methodist Cem.		22d. LOCATION (City, town, or county) (State) Mt. Vernon, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruby C. Ziegler ADDRESS Salisbury, Maryland				24a. REC'D BY REGISTRAR Mary W. Holloman DATE 8-17-56		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1911		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
MARRIED		1935		NEW YORK		NEW YORK		NEW YORK		NEW YORK		AUG 15 1956		NEW YORK		NEW YORK	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
MANAGER		1940		NEW YORK		NEW YORK		NEW YORK		NEW YORK		AUG 15 1956		NEW YORK		NEW YORK	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
HEART DISEASE		1956		NEW YORK		NEW YORK		NEW YORK		NEW YORK		AUG 15 1956		NEW YORK		NEW YORK	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
NATURAL		1956		NEW YORK		NEW YORK		NEW YORK		NEW YORK		AUG 15 1956		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAMES H. HARRIS		1956		NEW YORK		NEW YORK		NEW YORK		NEW YORK		AUG 15 1956		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAMES H. HARRIS		1956		NEW YORK		NEW YORK		NEW YORK		NEW YORK		AUG 15 1956		NEW YORK		NEW YORK	

BUREAU V. 3

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8789

CERTIFICATE OF DEATH

08777

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Janie Middle Baynard Last Baynard		4. DATE OF DEATH Month August Day 17 Year 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56	IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca. of left breast DUE TO (c) Ca. of left breast			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170X			
INTERVAL BETWEEN ONSET AND DEATH ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 7 , 19 56 , to Aug. 17 , 19 56 , that I last saw the deceased alive on Aug. 17 , 19 56 , and that death occurred at 8:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 8/17/56			
ACTUAL SIGNATURE J. Juerman		M.D. Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 20	22c. NAME OF CEMETERY OR CREMATORY BURRSVILLE	22d. LOCATION (City, town, or county) (State) CENTREVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar H. Lane		24a. REC'D BY REGISTRAR Aug 23 1956	
ADDRESS Church Hill Md.		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Aug 20 1956		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

AUG 23 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 21 Film G202 8-31-56											
8826											
Reg. Dist. No. 835											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>				c. LENGTH OF STAY IN 1b <u>58 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Little Water Street</u>						d. STREET ADDRESS <u>Little Water</u>					
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Nichols</u> Last <u>Bennett</u>						4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1956</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-3-1897</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>19</u> Min. <u>36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wood</u>		11. BIRTHPLACE (State or foreign country) <u>Sharptown, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jonathan R. Bennett</u>						14. MOTHER'S MAIDEN NAME <u>Naoma Nichols</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>***** 213-01-7857</u>		17. INFORMANT <u>Jack Bennett, son, Sharptown Md.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO <u>919.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DISCHARGE OF SHOTGUN IN POSSESSION OF DECEASED.</u> DUE TO (c) <u>minutes.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Discharge of shotgun in possession of deceased.</u>							
20c. TIME OF INJURY Month, Day, Year <u>3:30</u> <u>Aug. 8,</u> 19 <u>56</u> Hour <u>3:30</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>			
				20f. (City or town) <u>Sharptown, Wicomico, Maryland</u>				(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Kendrick Mc. Gullough</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Kendrick Mc. Gullough, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>8-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Firemans</u>		22d. LOCATION (City, town, or county) <u>Sharptown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marvel</u>						ADDRESS <u>Sharptown, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary C. Owens</u>	

DATE SIGNED

August 9, 1956

BUREAU, V. B.

MAY 13 1956

RECEIVED

8790

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS c/o Norman Elliott	
3. NAME OF DECEASED (Type or print) First Frederick Middle Bowdle Last Blades		4. DATE OF DEATH Month August Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/22/1888
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	11. BIRTHPLACE (State or foreign country) Preston, Md. USA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William T. Blades	
14. MOTHER'S MAIDEN NAME Mary A. Dukes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk. No	
16. SOCIAL SECURITY NO. 222-03-8257		17. INFORMANT Deer's Head State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 302X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ --		INTERVAL BETWEEN ONSET AND DEATH 2 wks. unk.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --		20c. TIME OF INJURY Month, Day, Year Hour 0 , M. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Maryland	
20f. (City or town) Salisbury, Maryland		(County) _____ (State) _____	
21. I certify that I attended the deceased from July 16, 1953 , to August 3, 1956 , that I last saw the deceased alive on Aug. 3, 1956 , and that death occurred at 3:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/3/56 ACTUAL SIGNATURE L. V. Maldve M.D. L. V. Maldve, M. D.			

MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 6 1956	22c. NAME OF CEMETERY OR CREMATORY Linchester	22d. LOCATION (City, town, or county) (State) Preston Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampton Son		24a. REC'D BY REGISTRAR Federalburg Md	24b. REGISTRAR'S SIGNATURE Mary W. Holloway

RECEIVED
AUG 14 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8791

CERTIFICATE OF DEATH

Reg. Dist. No. 832

08781

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>BURLEY STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORA KATHERINE BRITTINGHAM</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 10 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 21, 1890</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DENARD W. BRITTINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET COOPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N</u> (If yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO. <u>MISS EMMA BRITTINGHAM</u>	
17. INFORMANT <u>MISS EMMA BRITTINGHAM</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 7</u> , 19 <u>56</u> , to <u>Aug 10</u> , 19 <u>56</u> (that I last saw the deceased alive on <u>Aug 9</u> , 19 <u>56</u> , and that death occurred at <u>5:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. Eikure</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md. Aug 10, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>8/12/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>OCEAN CITY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Buchage</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>8-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

RECEIVED

AUG 14 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

18782
337

8792

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Men. Hospital		d. STREET ADDRESS 227 Broad St	
3. NAME OF DECEASED (Type or print) First MILDRED Middle DORIS Last CANTWELL		4. DATE OF DEATH Month AUGUST Day 21 at 19 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1908
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beauty Shpp Operator		10b. KIND OF BUSINESS OR INDUSTRY Beauty Shop	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Vernon C. Williams		14. MOTHER'S MAIDEN NAME Virginia E. Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. W. Maurice Cantwell (Husband)		Address 227 Broad St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - Crushed Chest DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) gave rise to the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto run off road	
20c. TIME OF INJURY Month, Day, Year 12:05 a.m. 8-21-1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1st St	20f. (City or town) (County) (State) Salisbury Wicomico Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 22 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR AUG 23 1956	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

BUREAU V. E.

AUG 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08783

8793

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>55 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Thomas</u> (Last) <u>Chaires</u>				4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1882</u>		9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy Man</u>		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Chaires (Chaires)</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. ---		17. INFORMANT <u>Deer's Head Hospital Records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma with multiple metastasis</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease with coronary insufficiency</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 26</u> , 19 <u>56</u> , to <u>Aug. 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>56</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Grisolia</u>		M.D. <u>Deer's Head State Hospital</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>8/20/56</u>	
PHYSICIAN'S NAME (Type) <u>Andres Grisolia, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-22-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>			

BUREAU V. B.

AUG 14 1956

RECEIVED
FBI
AUG 14 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8827 CERTIFICATE OF DEATH

08784
332

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4123 Roland Avenue, Baltimore 11, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>People Shade Nursing Home</u>				d. STREET ADDRESS <u>4123 Roland Ave.</u>			
3 NAME OF DECEASED (Type or print)				4 DATE OF DEATH			
First <u>Lillie</u> Middle <u>May</u> Last <u>Chambers</u>				Month <u>August</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Sept. 30, 1875</u>	
9 AGE (In years last birthday) <u>80</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Collins</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Sweitzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>No</u>		17. INFORMANT <u>Henry Lee Chambers (son)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Auricular fibrillation</u> DUE TO (c) <u>Cardiac enlargement</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 days</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension (several years)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 12, 1956</u> , to <u>August 17, 1956</u> , that I last saw the deceased alive on <u>August 17, 1956</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. F. Spitznagle</u> M.D.				ADDRESS (Street, city or town, state) <u>Mardela, Md.</u>			
PHYSICIAN'S NAME (Type) <u>V. F. Spitznagle, M.D.</u>				DATE SIGNED <u>8/17/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u>				ADDRESS <u>3631 Falls Road, Baltimore</u>			
24a. REC'D BY REGISTRAR <u>Aug 20 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Mary M. Hallways</u>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 41 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

MAY 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8794

CERTIFICATE OF DEATH

Reg. Dist. No.

18785332
291

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 yr 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First LOUISA Middle M. Last CONN		4. DATE OF DEATH Month August Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1867
9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Nichols		14. MOTHER'S MAIDEN NAME Louisa M. Riggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. --	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 17, 1955 , to August 14, 1956 , that I last saw the deceased alive on August 14, 1956 , and that death occurred at 10: AM , from the causes and on the date stated above.		
ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital		DATE SIGNED 8/14/56
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		Salisbury, Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Aug 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Plum Creek Cemetery
22d. LOCATION (City, town, or county) (State) Allegheny Co. Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE Hamilton Harrison ADDRESS St. Michaels		24a. REC'D BY REGISTRAR Aug 15, 56
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUG 17 1956

BUREAU K. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88786

8795

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 12	
4. NAME OF DECEASED (Type or print) First CHARLES Middle SHERMAN Last DENNY		4. DATE OF DEATH Month AUGUST Day 14 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1887
9. AGE (In years last birthday) yrs 69		IF UNDER 1 YEAR IF UNDER 24 HRS Months 2 Days 3 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Dept. Store Manager		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles G. Denny		14. MOTHER'S MAIDEN NAME Ida Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NAK x No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. C. Sherman Denny Jr. (Son)		Address Baltimore, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-13 , 19 56 , to 8-14 , 19 56 , that I last saw the deceased alive on 8-14 , 19 56 , and that death occurred at 6:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Salisbury, Maryland Aug. 14 1956			
ACTUAL SIGNATURE William R. Ellis M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
PHYSICIAN'S NAME (Type) Salisbury, Maryland		22b. DATE THEREOF Aug. 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.		ADDRESS 715 Light St.	
24a. REC'D BY REGISTRAR Aug 20 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU N. Y.

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8796 CERTIFICATE OF DEATH

Reg. Dist. No.

18782
332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 208 West Isabella St.,			
3. NAME OF DECEASED (Type or print) First WARDEN Middle O DELL Last DENSON				4. DATE OF DEATH Month 8 Day 6 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1900	9. AGE (In years last birthday) yrs. 56	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Foods		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ephraim Denson				14. MOTHER'S MAIDEN NAME Emma Lawrence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-70-5151		17. INFORMANT Mrs. W.O. Denson, Same			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) antecedent cerebral thrombosis DUE TO (c) Cerebral arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 mos. 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May , 19 56 , to Aug , 19 56 , that I last saw the deceased alive on Aug 6 , 19 56 , and that death occurred at 11:39 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry Mattax M.D.				ADDRESS (Street, city or town, state) Salisbury, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. Harry Mattax, 711 Camden Ave., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/56		22c. NAME OF CEMETERY OR CREMATORY Siloan Cemetery		22d. (City or town) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Norman F. Barber				ADDRESS The Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 8-13-56	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

RECEIVED

AUG 14 1956

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8797

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>J</u> Last <u>Ellis</u>				4. DATE OF DEATH Month <u>8-</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14 1913</u>		9. AGE (In years last birthday) <u>42</u> yrs.	10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Garage (mechanic)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>		11. BIRTHPLACE (State or foreign country) <u>H. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>H. S. A.</u>	
13. FATHER'S NAME <u>Omery Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Lawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-09-2877</u>		17. INFORMANT <u>Warren Ellis</u> Address <u>Selbyville Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral circulatory failure under anesthesia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized lympho-sarcoma</u> DUE TO (c) <u>Hypertensive cardio-vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Weeks</u> <u>Months</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient died under anesthesia for an exploratory laporotomy..</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9-15 PM</u> <u>8-16-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital O.R.</u>		20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-18-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Red Mans Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Selbyville Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>				ADDRESS <u>Frankford Del.</u>		24a. REC'D BY REGISTRAR <u>AUG 22 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Margt. Holloway</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 29 1906

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08790

Reg. Dist. No. 332

8798

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN <u>15</u> days <u>Princess Anne</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R F D # 1</u>					
3. NAME OF DECEASED (Type or print) <u>William Isaac Gates</u>		4. DATE OF DEATH Month <u>8-13</u> Day <u>19</u> Year <u>56</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1908</u>				
9. AGE (In years keep birthday) <u>48</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>2</u> Days <u>3</u></td> <td>Hours <u> </u> Min. <u> </u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>2</u> Days <u>3</u>	Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months <u>2</u> Days <u>3</u>	Hours <u> </u> Min. <u> </u>						
11. BIRTHPLACE (State or foreign country) <u>Quantico, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Issac Gates</u>		14. MOTHER'S MAIDEN NAME <u>Anna Wainwright</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>					
17. INFORMANT <u>Annie Gates, Quantico, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>8/12 X</u> DUE TO (b) <u>Fracture of skull</u> (c) <u>Bilateral fracture of the tibia and fibula</u> </td> <td style="width: 20%;"> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> </td> </tr> <tr> <td colspan="2"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>8/12 X</u> DUE TO (b) <u>Fracture of skull</u> (c) <u>Bilateral fracture of the tibia and fibula</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>8/12 X</u> DUE TO (b) <u>Fracture of skull</u> (c) <u>Bilateral fracture of the tibia and fibula</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by a car while crossing road in front of Smitty Inn.</u>					
20c. TIME OF INJURY Month, Day, Year <u>9:30</u> Hour <u>8-10-56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>					
20f. (City or town) <u>Princess Anne Somerset Md.</u>		20g. (County) <u>Somerset</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>8-14-56</u>					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/56</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Head of Creek, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. B. Bivall</u>		24. REC'D BY REGISTRAR <u>171956</u>					
ADDRESS <u>Bivalve, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
BUREAU V. 1
3 17 1956

CERTIFICATE OF DEATH

Reg. Dist. No.

08791

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GOWIE</u>		4. DATE OF DEATH Month Day Year <u>August 27 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1956</u>
9. AGE (In years last birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>7 56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>NORMAN</u>		14. MOTHER'S MAIDEN NAME <u>GOWIE IYA LOIS ROSE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS IYA GOWIE</u>		Address <u>Whaleyville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, intraventricular</u> 11:05 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Difficult labor - Cervical stenosis</u> DUE TO (c) <u>and dry delivery (anterior fluid lodged in cervix)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRA TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity - Weight approx 3 lbs</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 27, 1956</u> , to <u>Aug 27, 1956</u> , that I last saw the deceased alive on <u>Aug 27, 1956</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. H. Sanderson Jr</u>		ADDRESS (Street, city or town, state) <u>926 N. Division St Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>R. H. Sanderson Jr</u>		DATE SIGNED <u>8/29/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>	
22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. HARRIS</u>	
24a. REC'D BY REGISTRAR DATE <u>9-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. HARRIS</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.I.

SEP 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8890 CERTIFICATE OF DEATH

08792

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland			
c. LENGTH OF STAY IN 1b 4 years 4 mo. 3 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 709 West Lombard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Harrington Last Harrington				4. DATE OF DEATH Month August Day 5 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1906		9. AGE (In years last birthday) 49 yrs		IF UNDER 1 YEAR Months 5 Days 19 Hours 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk		10b. KIND OF BUSINESS OR INDUSTRY Unk		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Harrington				14. MOTHER'S MAIDEN NAME Mary Gordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. unk.		17. INFORMANT Hospital Records Address Deer's Head State Hospital Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 10 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Paresis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11. Month, 19 Day, 19 Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1952 , to August 5 , 19 56 , that I last saw the deceased alive on August 5 , 19 56 , and that death occurred at 1:30 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/5/56 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D. Deer's Head State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/8/56		22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		22d. LOCATION (City, town, or county) (State) Salisbury Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company-Salisbury Md.				24a. REC'D BY REGISTRAR Aug 8 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BRITISH V.F.

9031 6 5.

RECEIVED

8801 CERTIFICATE OF DEATH

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Court Street</u>			
3. NAME OF DECEASED (Type or print) <u>William Albert Hitchens</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Laurel, Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Hitchens</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Hitchens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>RR - A205814</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Ca. of prostatic gland with generalized metastasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury, Maryland</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>January 30, 1956</u> , to <u>August 7, 1956</u> , that I last saw the deceased alive on <u>August 7, 1956</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Juerman</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>W. Juerman, M. D.</u>				DATE SIGNED <u>8/7/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer's Head State Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Juerman</u>				ADDRESS <u>Deer's Head State Hospital</u>		24a. REC'D BY REGISTRAR <u>W. H. Hallways</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Hallways</u>		DATE <u>8/10/56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

MIG 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8802 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08794

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POWELLVILLE Powellville															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Pen. Gen. Hospital				d. STREET ADDRESS In Village			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First OSSIE Middle BRAXTON Last HOLLAND				4. DATE OF DEATH Month AUGUST Day 17 Year 19 56																	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 4, 1896		9. AGE (In years last birthday) 60 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td>7</td> <td>13</td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	7	13		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
7	13																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME John J. Holland				14. MOTHER'S MAIDEN NAME Georgianna Parker																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marcella Jones Holland (Wife) Powellville Maryland																
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH 1 year </td> </tr> <tr> <td colspan="2"> DUE TO (b) Arterio-sclerotic Heart Disease </td> </tr> <tr> <td colspan="2"> DUE TO (c) </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 year	DUE TO (b) Arterio-sclerotic Heart Disease		DUE TO (c)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 year																			
DUE TO (b) Arterio-sclerotic Heart Disease																					
DUE TO (c)																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 19 1956															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Powellville, Maryland															
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 21 1956		24b. REGISTRAR'S SIGNATURE Mary Holloway															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 21 1900

RECEIVED

8893

CERTIFICATE OF DEATH

08795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>				d. STREET ADDRESS <u>Bivalve</u>			
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>James</u> Last <u>Horner</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>28</u> Year <u>19 56</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1951</u>		9. AGE (In years last birthday) yrs <u>4</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>Roy Horner</u>				14. MOTHER'S MAIDEN NAME <u>Stella Miezen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Roy Horner, Bivalve, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Encephalitis Costrum Equine</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>50 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>56</u> to <u>8/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>56</u> , and that death occurred at <u>10:57 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke, Maryland</u>		DATE SIGNED <u>8/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Corneille M. Spivey</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Marjorie Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1956

RECEIVED

884

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS Hudson Drive (R.D. # 5)	
3. NAME OF DECEASED (Type or print) First ALFORD Middle WILLIAM Last HUDSON		4. DATE OF DEATH Month AUGUST Day 3 rd Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 30, 1913
9. AGE (In years last birthday) yrs. 43		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector - Employee of Wayne Pump Co.		10b. KIND OF BUSINESS OR INDUSTRY Salisbury, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jacob William Hudson		14. MOTHER'S MAIDEN NAME Berdie P. Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Gibbons (Sister) Lakewood - Off R.T. #13		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary DUE TO old myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20 , 19 54 to 8/3 , 19 56 , that I last saw the deceased alive on 8/2 , 19 56 , and that death occurred at 11 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Andrew Mitchell		ADDRESS (Street, city or town, state) Maryland Ave. DATE SIGNED August 4 1956	
PHYSICIAN'S NAME (Type) Dr. Andrew Mitchell		M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1956

BUREAU V. A.

8805

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 426 Priscilla St	
3. NAME OF DECEASED (Type or print) First DELLA Middle Last HURLEY		4. DATE OF DEATH Month AUGUST Day 9th Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1881
9. AGE (In years last birthday) yrs 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Athol (Wicomico Co.) Md.	
13. FATHER'S NAME George Lloyd		12. CITIZEN OF WHAT COUNTRY? U S A	
14. MOTHER'S MAIDEN NAME Sarah Jackson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO		17. INFORMANT Mr. William E. Hurley (Husband) Address 426 Priscilla St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Stroke DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1 , 19 56 , to 8-9 , 19 56 , that I last saw the deceased alive on 8-9 , 19 56 , and that death occurred at 6 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Smith		ADDRESS (Street, city or town, state) Medical Center DATE SIGNED August 10 1956	
PHYSICIAN'S NAME (Type) Dr. William Smith		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 11, 1956	Mardela Cemetery (Old)	Mardela, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR AUG 13 1956	
24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>			

RECEIVED

MAY 1 1964

BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8828

CERTIFICATE OF DEATH

Reg. Dist. No.

08798

331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2		d. STREET ADDRESS R.D.# 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle SAMUEL Last JONES		4. DATE OF DEATH Month AUGUST Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months 6 Days 10 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Jesse Jones		14. MOTHER'S MAIDEN NAME Mary Coffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Emma L. Jones (Wife) Address R.D.# 2 (Charity) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Cerebral and general arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 50 to August 10, 19 56 , that I last saw the deceased alive on August 10, 19 56 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) 303 East St. DATE SIGNED August 13/56	
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler M.D.		Delmar, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 13, 1956	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memorial Gardens, Inc.		22d. LOCATION (City, town, or county) (State) Near Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REG'D BY REGISTRAR AUG 14 1956 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

U. S. A.

AUG 14 1956

RECEIVED

8806

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALLEN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Box 45A R.R. 2</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>KING</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 30 1956</u>	
5. SEX <u>MALE</u>	6 COLOR OR RACE <u>COI</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1936</u>
9. AGE (In years lost birthday) yrs. <u>20</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>OLIVER LEON KING JR.</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH FRANCES WESSELLS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>FATHER - OLIVER KING JR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abruptio Placenta</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>---</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u>		(County) (State)	
21. I certify that I attended the deceased from <u>8-30, 1956</u> to <u>8-30, 1956</u> , that I last saw the deceased alive on <u>8-30, 1956</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>8/30/56</u>	
PHYSICIAN'S NAME (Type) <u>---</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>9-5-56</u>	
ADDRESS <u>---</u>		24b. REGISTRAR'S SIGNATURE <u>Maryland Registrar</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 6 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG203 9-14-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

68800

336

8829

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 Elizabeth				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sallie Middle Mae Last Lake				4. DATE OF DEATH Month Aug. Day 28, Year 1956			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1914	9. AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Delmar, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W.A. Brittingham				14. MOTHER'S MAIDEN NAME Elizabeth Arvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT W.A. Brittingham, Delmar, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Heart Disease DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. about 3 hours DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Aug 28, 1956 to Aug 28, 1956 , that I last saw the deceased alive on Aug 28, 1956 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. H. L. ...		M.D. Primer Rd		DATE SIGNED Aug 30/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-30-56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Delaware			
23. FUNERAL DIRECTOR'S SIGNATURE W. S. ...		ADDRESS ...		24a. REC'D BY REGISTRAR ...	24b. REGISTRAR'S SIGNATURE Harry ...		

MEDICAL CERTIFICATION

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BUNIAU V. S.

SEP 4 1950

RECEIVED

8830

CERTIFICATE OF DEATH

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wetipquin				c. LENGTH OF STAY IN 1b Most of life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Quantico, Md. Rt. # 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Lankford				4. DATE OF DEATH Month 8 - Day 8 - Year 1956			
5. SEX Female		6. COLOR OR RACE A.A.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-1868	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 1 Days 12 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Wetipquin, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-4763		17. INFORMANT Samuel Lankford, Quantico, Md., Rt. # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 1 month Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 July, 1956 to 8 Aug., 1956 that I last saw the deceased alive on 8 Aug., 1956 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. A. Purnell M.D. 4-24-1956				DATE SIGNED ST 10000 56			
PHYSICIAN'S NAME (Type) F. A. PURNELL, M.D. Salisbury, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-56		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Wetipquin, Wicomico Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE Aug 10 1956		24b. REGISTRAR'S SIGNATURE Mary A. Holloway	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1900

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08802

8807 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>since 7/24/56</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crisfield</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u> <u>Salisbury, Md.</u>				STREET ADDRESS (if rural give location) <u>Asbury Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Eily</u> (First) <u>Jean</u> (Middle) <u>Maddox</u> (Last)				4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 11, 1925</u>	9. AGE last birthday <u>30</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>		IF UNDER 24 HRS Hours <u>19</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Avery Middleton</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>270-20-2090</u>		17. INFORMANT & ADDRESS <u>Patient when admitted</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cor Pulmonale -</u>						<u>20 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>pulmonary tuberculosis</u>						<u>4 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11</u> A. <u>17</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 21, 1956</u> , to <u>Aug. 17, 1956</u> , that I last saw the deceased alive on <u>Aug. 17, 1956</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. D. Hurdle</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>8/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug. 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>SUNNYBRIDGE CEMETERY</u>		LOCATION (City, town, or county) (State) <u>CRISFIELD, MARYLAND</u>	
24. REC'D BY REGISTRAR DATE <u>8-18-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW S. ...</u> ADDRESS <u>CRISFIELD, MARYLAND</u>			

U. V. E.

3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8898

CERTIFICATE OF DEATH

Reg. Dist. No.

08803337

260

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>--</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Maddox</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Maddox</u>		14. MOTHER'S MAIDEN NAME <u>Jane Gordy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Deer's Head Hospital Records</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis with right hemiplegia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 14, 19 56</u> , to <u>August 15, 19 56</u> , that I last saw the deceased alive on <u>August 15, 19 56</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. V. J. J. J.</u> M.D.		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>8/15/56</u>	
PHYSICIAN'S NAME (Type) <u>V. J. J. J., M.D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westover</u>		22d. LOCATION (City, town, or county) (State) <u>Westover, Som. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>8/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holladay</u>	

BUREAU V. 2

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

188804

Reg. Dist. No. 133

1. PLACE OF DEATH a. COUNTY 8809 Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 24 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin	
3. NAME OF DECEASED (Type or print) First Robert Middle Maddox Last 4. DATE OF DEATH Month 8 Day 19 Year 1956		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Manokin, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Maddox		14. MOTHER'S MAIDEN NAME Fanny DeShield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. 2	
17. INFORMANT Next Wife: Mary Ann Maddox		Address Manokin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 23 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Passenger in a two car collision on 8-18-56 R F D # 13	
20c. TIME OF INJURY Month, Day, Year 2:30 P.m. 8-18-56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Kings Creek Somerset Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8-21-56	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 8/28/56	22c. NAME OF CEMETERY OR CREMATORY Johns Wesley	22d. LOCATION (City, town, or county) (State) Manokin Md
23. FUNERAL DIRECTOR'S SIGNATURE William H. James		ADDRESS Princess Anne	
		24a. REC'D BY REGISTRAR Mary W. Hollaway	24b. REGISTRAR'S SIGNATURE Mary W. Hollaway
		DATE 8-23-56	

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8831

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonberg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Vernon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lemon Nursing Home</u>		d. STREET ADDRESS <u>Mt. Vernon</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>A</u> Last <u>Marshall</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1868</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Green</u>		14. MOTHER'S MAIDEN NAME <u>Mary Phillip</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vaughan Marshall, Salisbury, Md.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>ILL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Accident</u> DUE TO (c) <u>Hypertension Cerebral Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8-1-1956</u> , to <u>8-25-1956</u> ; that I last saw the deceased alive on <u>8-25-1956</u> , and that death occurred at <u>9:05</u> M, from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D. <u>Med. Center, Shy Md.</u>		<u>8/27/56</u>
PHYSICIAN'S NAME (Type) <u>William B. Smith, M.D.</u> <u>Medical Center, Salisbury, Md.</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hinson</u>		ADDRESS <u>Princess Anne, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>9/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Halloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covered papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 29 1956
U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retype carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88806

8810

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Saratoga St				d. STREET ADDRESS 203 Saratoga St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HOMER Middle DAVID Last MOSER				4. DATE OF DEATH Month AUGUST Day 25 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1904		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Wayne Pump Co. (Employee)				10b. KIND OF BUSINESS OR INDUSTRY Pandora, Ohio		11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Christ Moser				14. MOTHER'S MAIDEN NAME Carolyn Sprunger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Mildred B. Moser (Wife) Address 203 Saratoga St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal cerebral carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, w/ kidney DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Camden Ave.				20g. (County) (Office)		20h. (State) Aug. 25 1956	
21. I certify that I attended the deceased from Aug. 25 , 19 56 , to Aug. 25 , 19 56 , that I last saw the deceased alive on Aug. 25 , 19 56 , and that death occurred at 7:48A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry Mattox				M.D. Camden Ave. (Office) Aug. 25 1956			
PHYSICIAN'S NAME (Type) Dr. Harry Mattox				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29 1956		22c. NAME OF CEMETERY OR CREMATORY Prairie Cemetery		22d. LOCATION (City, town, or county) (State) Fort Wayne, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE P. D. Heasuch	

DECEMBER 11

1956

1956

CERTIFICATE OF DEATH

Reg. Dist. No. 332

8811

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 yrs. 4 mo.		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph		First		Middle		Last Oller		4. DATE OF DEATH August 18 19 56		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/1886		9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Joseph Oller		14. MOTHER'S MAIDEN NAME Susie McFarren													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Ink.		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexy DUE TO (b) Chronic brain syndrome associated with neurosyphilis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 years ?													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis of aorta; pulmonary emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from April 2, 1952 , to August 18, 1956 , that I last saw the deceased alive on Aug. 18, 1956 , and that death occurred at 3:45 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 8/18/56											
ACTUAL SIGNATURE Andres Grisolia		M.D. Deer's Head State Hospital		Salisbury, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		22b. DATE THEREOF Aug 21-56		22c. NAME OF CEMETERY OR CREMATORY Crematorium Bld		22d. LOCATION (City, town, or county) (State) Baltimore									
23. FUNERAL DIRECTOR'S SIGNATURE Booker M. West		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary M. Hollaway									

E-J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The [redacted] [redacted] that the death certificate be executed within 24 hours of [redacted] death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8812

CERTIFICATE OF DEATH

Reg. Dist. No. 88808

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle OX Last OX		4. DATE OF DEATH Month August Day 4 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kingston, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward Oxx		14. MOTHER'S MAIDEN NAME Elizabeth Vickers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mabel P. Derby (Friend)		Address 313 Penn St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary artery sclerosis DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 15 min ? years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 2 , 19 56 , to Aug 4 , 19 56 , that I last saw the deceased alive on Aug 4 , 19 56 , and that death occurred at 12:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Mattax		ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. Harry Mattax		DATE SIGNED August 6 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR AUG 7 1956 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

RECEIVED

AUG 7 1956

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8832

CERTIFICATE OF DEATH

Reg. Dist. No.

88899
32 ✓

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2				d. STREET ADDRESS R.D.# 2			
3. NAME OF DECEASED (Type or print) First DANIEL Middle JAMES Last PARSONS				4. DATE OF DEATH Month AUGUST Day 29 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 3 Days 21	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Near Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John E. Parsons				14. MOTHER'S MAIDEN NAME Jane Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Minnie Parker (Wife) R.D.# 2 (Charity) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, acute pulmonary edema 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						INTERVAL BETWEEN ONSET AND DEATH unusual 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 53 to 19 56 , that I last saw the deceased alive on 4/12 19 56 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 703 Grove St. DATE SIGNED August 29 1956							
ACTUAL SIGNATURE Ernest Larmore M.D.				PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore M.D. Delmar, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 1956		22c. NAME OF CEMETERY OR CREMATORY Charity Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24. REC'D BY REGISTRAR AUG 30 1956			
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 30, 1956

RECEIVED

8813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar, Md. (Del. P.O.)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Rt. 2			
3. NAME OF DECEASED (Type or print) First STEPHEN Middle H. Last PARSONS				4. DATE OF DEATH Month August Day 9 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1876	
9. AGE (In years last birthday) yrs 79		10. IF UNDER 1 YEAR Months 9 Days 19 Hours 56		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming			
13. FATHER'S NAME John Edwin Parsons				14. MOTHER'S MAIDEN NAME Janie Elliott Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		(If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. James Edward Parsons (Son) R.D.# 2 City Deer's Head Hospital Records, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) Nephrosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 27, 19 56 , to August 9, 19 56 , that I last saw the deceased alive on August 9, 19 56 , and that death occurred at 8:25AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andres Grisolia M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland			
PHYSICIAN'S NAME (Type) Andres Grisolia, M. D.				DATE SIGNED 8/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR Aug 13 1956	
24b. REGISTRAR'S SIGNATURE May H. Holloway							

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY

LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8814

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, filed for registration

CERTIFICATE OF DEATH

08812

Reg. Dist. No. 032

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>San Ben Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>E</u> Middle <u>Penbert</u> Last				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1871</u> <u>85</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Mt Vernon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Florence Hardy</u> Address <u>?</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>						<u>3 days</u>	
DUE TO <u>Nephritis</u>						<u>unk.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Thrombosis</u>						<u>Week</u>	
DUE TO (c) <u>Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>?</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. ft.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury Wicomico Rd</u>	
				20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD</u>			
21. I certify that I attended the deceased from <u>Aug 10, 1956</u> to <u>Aug 15, 1956</u> that I last saw the deceased alive on <u>Aug 15, 1956</u> and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>8/21/56</u>			
PRINTED NAME (Type) <u>G. Herbert Sembley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 19, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Vernon Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Vernon Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booster McWah</u> ADDRESS <u>Salisbury</u>				24a. REC'D BY REGISTRAR DATE <u>8-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Gowen</u>	

1 1/2 1880

gc

1880

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 32

18811

8815

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martina</u> Middle <u>L.</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Anthony Banks</u>				14. MOTHER'S MAIDEN NAME <u>Hester Bawley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Jnk.</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Deer's Head Hospital Records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease,</u> DUE TO <u>decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>	(County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>August 21, 1956</u> to <u>August 23, 1956</u> , that I last saw the deceased alive on <u>August 23, 1956</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. Guerman</u>			ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>			DATE SIGNED <u>8/23/56</u>	
PHYSICIAN'S NAME (Type) <u>V. Guerman, M. D.</u>			<u>Salisbury, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meekins Neck</u>		22d. LOCATION (City, town, or county) (State) <u>Meekins Neck, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. M. Hollaway Jr.</u>			ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. 1000

9

02/11/11

8816

CERTIFICATE OF DEATH

08813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 514 E. Locust St		d. STREET ADDRESS 514 E. Locust St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle ELIZAH Last POWELL		4. DATE OF DEATH Month AUGUST Day 16 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Powell		14. MOTHER'S MAIDEN NAME Phoebe Ellen Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Eva Mae Powell (Wife)		Address 514 E. Locust St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 7 hrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 12 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-10 , 19 56 , to 8-16 , 19 56 , that I last saw the deceased alive on 8-16 , 19 56 , and that death occurred at 11:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carl M. Beardsley		ADDRESS (Street, city or town, state) Maryland Ave. DATE SIGNED August 17 1956	
PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 19, 1956	22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	22d. LOCATION (City, town, or county) (State) Near Liberty Town, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9. 10. 1956

RECEIVED

332

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

BUREAU A. S.

SEP 4 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G2... 1-1-6 at

88815

8834

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 467			
c. LENGTH OF STAY IN 1b <u>3 yrs</u>				d. STREET ADDRESS <u>RED</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lemon Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Granville Andrew Reddish</u>				4. DATE OF DEATH Month Day Year <u>Aug. 28 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1870</u>	9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Reddish</u>				14. MOTHER'S MAIDEN NAME <u>Hester Hearn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-9123</u>		17. INFORMANT Address <u>Athelyn Reddish, Newark, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-1-1956</u> to <u>8-28-1956</u> , that I last saw the deceased alive on <u>8-28-1956</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm B Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Med. Center, Salisbury, Md.</u> DATE SIGNED <u>8/3-9/56</u>			
PHYSICIAN'S NAME (Type) <u>William B. Smith, M.D.</u>				Medical Center, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm B Smith</u> ADDRESS <u>Delmar, Delaware</u>				24a. REC'D BY REGISTRAR <u>4</u> DATE <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>May J. Holloway</u>	

BUREAU V. S.

SEP 4 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8817

CERTIFICATE OF DEATH

88816

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 5 1/2 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1002 N. Division St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Paul Middle J. Last Richardson, Jr.		4. DATE OF DEATH Month Aug. Day 25 Year 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1912	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min 44	IF UNDER 24 HRS Months 44 Days 44 Hours 44 Min 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul J. Richardson, Sr.				14. MOTHER'S MAIDEN NAME Martha W. Henwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosis DUE TO (c) 1 year						INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General rheumatoid ankylosing arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15 , 19 51 , to Aug. 25 , 19 56 , that I last saw the deceased alive on August 25 , 19 56 , and that death occurred at 10:35 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 8/25/56			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/56		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland Norman F. Baker				24a. REC'D BY REGISTRAR DATE 8-28-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

RECEIVED

AUG 13 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8818

CERTIFICATE OF DEATH

Reg. Dist. No.

0881832

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>PHILA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILA. /</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>5236 N. 2nd ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>Ridge</u> Last <u>Ridge</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 21, 1875</u>	9. AGE (in years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN McARTHUR</u>				14. MOTHER'S MAIDEN NAME <u>McCORKLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>314 HAZEL ST. SALISBURY, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> DUE TO <u>Anterior Sclerotic P. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>you</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>you</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-10</u> , 19 <u>56</u> , to <u>8-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 19</u> , 19 <u>56</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				ADDRESS (Street, city or town, state) <u>407 Camden Ave. Salisbury, Md.</u>		DATE SIGNED <u>8-19-56</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Royer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLSIDE CEMT.</u>		22d. LOCATION (City, town, or county) (State) <u>WILLOW GROVE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson Gault, EASTON, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>8-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

REAU V. E.

MAY 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8819

CERTIFICATE OF DEATH

Reg. Dist. No. 332 18818

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>			
c. LENGTH OF STAY IN 1b <u>19 Days</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Schoolfield</u> Last <u>Schoolfield</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 - 1875</u>	9. AGE (In years last birthday) <u>81 1/4</u> yrs	IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u> Hours <u>44</u> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Street Snow Hill</u>		11. BIRTHPLACE (State or foreign country) <u>Stowellville, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Harry Schoolfield</u>			
14. MOTHER'S MAIDEN NAME <u>Sallie Schoolfield</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO <u>2-18-05-8561</u>				17. INFORMANT <u>Mrs. Lucille Schoolfield, Snow Hill, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>11 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>56</u> , to <u>8/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/31</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul J. Sidmore</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>			
PHYSICIAN'S NAME (Type) <u>Paul J. Sidmore</u>				DATE SIGNED <u>8/31/56</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF <u>Sept. 3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wt. Wally</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Pk 44 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Halloway</u>				24a. REC'D BY REGISTRAR DATE <u>9/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Halloway</u>	

BUREAU V. S.

SEP 7 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8820

CERTIFICATE OF DEATH

08819

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Paraske General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle Last <u>Skinner</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cokeed</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1924</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Power Trg. Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Wilson, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Farmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>240-32-8445</u>		17. INFORMANT <u>Flossie Farmer, Flower St, Berlin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous intracerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 6</u> , 19 <u>56</u> , to <u>Aug 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 6</u> , 19 <u>56</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Mattax</u>			ADDRESS (Street, city or town, state) <u>211 Camden Avenue, Salisbury, Md.</u>				
PHYSICIAN'S NAME (Type) <u>HARRY MATTAX</u>			DATE SIGNED <u>8/8/56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Worcester Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u></u>	
				DATE <u></u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

BUREAU V. S.

AUG 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8835
CERTIFICATE OF DEATH

08820
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Personsbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Personsbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Smith</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Personsbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mahalia L. Luncorn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Elwin Smith</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Jan 1956</u> to <u>14 Aug 1956</u> , that I last saw the deceased alive on <u>14 Aug 1956</u> , and that death occurred at <u>6:17 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. A. Purnell</u>		DATE SIGNED <u>14 Aug 56</u>	
PHYSICIAN'S NAME (Type) <u>E. A. PURNELL</u>		ADDRESS (Street, city or town, state) <u>653 N. Main St. Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
DATE <u>Aug. 15, 1956</u>			

BUREAU V. M.

AUG 16 1956

RECEIVED

8836

CERTIFICATE OF DEATH

Reg. Dist. No. 08821

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 1 Salisbury, Maryland		d. STREET ADDRESS R.D. # 1 Salisbury	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First WILLIAM Middle LOUIS Last SMITH		4. DATE OF DEATH Month AUGUST Day 25 Year 1956	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 18, 1870
9 AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 9 Days 7 Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11 BIRTHPLACE (State or foreign country) R.D. # 1 Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William Louis Smith		14. MOTHER'S MAIDEN NAME Lydia Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Clifford P. Marshall (Daughter) R.D. # 1 (Shad Point) Salisbury, Maryland	
17. INFORMANT Mrs. Clifford P. Marshall (Daughter) R.D. # 1 (Shad Point) Salisbury, Maryland		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage SCIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) arterio sclerosis	
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-10 , 19 56 , to 8-25 , 19 56 that I last saw the deceased alive on 8-25 , 19 56 , and that death occurred at 1:25A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Maryland Ave. DATE SIGNED August 26 1956	
ACTUAL SIGNATURE Earl Beardsley M.D.			
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 27, 1956	22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 8/28/56	
24b. REGISTRAR'S SIGNATURE P. H. March			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

03 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8821

CERTIFICATE OF DEATH

Reg. Dist. No.

08822

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Box 67 - Ocean City Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stephens</u>				4. DATE OF DEATH Month Day Year <u>August 5 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 5-1952</u>	
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>2 4 0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Walter Joseph Stephens</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA CLAUDE PERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>56</u> to <u>8/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>56</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert L. Baker</u> M.D. <u>Salisbury Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Robert L. Baker</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR DATE <u>8-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloman</u>	

RECEIVED
AUG 14 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8837 CERTIFICATE OF DEATH

08823

Reg. Dist. No.

332

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>630 Stamford Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Logan</u> Middle <u>W.</u> Last <u>Sterling</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1900</u>	9. AGE (In years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee of Westinghouse Corp.</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Severn Sterling</u>				14. MOTHER'S MAIDEN NAME <u>Martha Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>220-07-1017</u>			
17. INFORMANT <u>Mrs. Doris Sterling, Baltimore, Maryland</u>				17. ADDRESS <u>630 Stamford Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>56</u> , to <u>8/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>56</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u>		DATE SIGNED <u>8/4/56</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H SAUNDERS</u>				NANTICOKE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. L. Merich</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR <u>Aug 6 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Followay</u>			

RECEIVED

AUG 7 1956

BUREAU W. D.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08824

8838

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Allen</u>		LENGTH OF STAY (in this place) <u>All life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Eden, Md. Rt. # 2</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - Allen</u>							
3. NAME OF DECEASED (Type or Print) <u>William Samuel Tull</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8 - 22 - 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1866</u>	9. AGE last birthday <u>90</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Wicomico Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Tull</u>				14. MOTHER'S MAIDEN NAME <u>Julia Tull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Julia Cornish, Eden, Md., Rt. # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>27 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis.</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-20, 1956</u> , to <u>8-22, 1956</u> , that I last saw the deceased alive on <u>8-22, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>24 Aug 56</u> M.D. <u>L. S. H. H. H.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-26-56</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		LOCATION (City, town, or county) (State) <u>Allen, Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR DATE <u>8/27/56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u> ADDRESS <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>			

BUNTING V. S.

1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8822

CERTIFICATE OF DEATH

88825

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				d. STREET ADDRESS R.D.# 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last WATSON				4. DATE OF DEATH Month AUGUST Day 27 Year th 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 5 Days 12 Hours Min. 	IF UNDER 24 HRS Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Ocean City Race Way) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Quantico, Maryland		11. BIRTHPLACE (State or foreign country) U S A		
13. FATHER'S NAME William Handy Watson				14. MOTHER'S MAIDEN NAME Grace White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Anna Belle Watson (Wife) R.D.# 3 Berlin, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain tumor. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 21, 1956 , to August 27, 1956 , that I last saw the deceased alive on August 27, 1956 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 116 E. Main St. (Office) DATE SIGNED August 28 1956							
ACTUAL SIGNATURE Philip A. Insley M.D. 116 E. Main St. (Office)							
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley Salisbury, Maryland August 28 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30, 1956	22c. NAME OF CEMETERY OR CREMATORY Lewis Cemetery		22d. LOCATION (City, town, or county) (State) Willards, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR August 30 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

RECEIVED

AUG 30 1956



BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

18826
337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C/O Post Master				d. STREET ADDRESS In Village			
3. NAME OF DECEASED (Type or print) First JOSHUA Middle BETHARD Last WHITE				4. DATE OF DEATH Month August Day 11 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1, 1890	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 9 Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rural Mail Carrier			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) R.D.# Parsonsborg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John White			14. MOTHER'S MAIDEN NAME Minnie Bethard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Yes			16. SOCIAL SECURITY NO. W.K.# 1		17. INFORMANT Mrs Ida J. White (Wife) Parsonsborg, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bed at 7 A.M.				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF August 14, 56		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.			ADDRESS		24. REG'D. BY REGISTRAR August 13 1956		
					24b. REGISTRAR'S SIGNATURE 		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8823
CERTIFICATE OF DEATH

88827

Reg. Dist. No. 18

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>5 1/2</u> years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>Mae</u> Last <u>White</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/1871</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Fairmount, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Leolin F. White</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Shores</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>12 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Glomerulonephritis, chronic</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epithelioma of left face; Ca. of parotid gland</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>51</u> , to <u>Aug. 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 31</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldre</u>			M.D. <u>Deer's Head State Hospital</u>			DATE SIGNED <u>8/22/56</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Maldre, M. D.</u>			Salisbury, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Muir Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fairmount Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Henson</u>				ADDRESS <u>Theresea Land</u>		24a. REC'D BY REGISTRAR DATE <u>9/4/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08828337

8824 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>24 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Louise</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>19 56</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1880</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House servant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Greenwell</u>			14. MOTHER'S MAIDEN NAME <u>Mary Somerville</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Deer's Head Hospital Records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of the left face</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 17</u> , 19 <u>56</u> , to <u>Aug. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 10</u> , 19 <u>56</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>			DATE SIGNED <u>8/11/56</u>		
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>		<u>Salisbury, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Hollywood Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Blake Mattingly</u>			ADDRESS <u>Leonardtown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/13/56</u>		
24b. REGISTRAR'S SIGNATURE <u>Thos. W. Hollings</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10-1

RECEIVED
AUG 14 1956
BUREAU V. 2

8825

CERTIFICATE OF DEATH

18829
 337
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury				c. LENGTH OF STAY IN 1b 4 yrs. 2mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rebecca Middle Wilson Last Wilson				4. DATE OF DEATH Month Aug. Day 24 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/1862	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 93		IF UNDER 24 HRS. Days 93 Hours 93 Min. 93			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wilson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT Hospital Records				Address -			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Arteriosclerosis generalized DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca. of left breast (amputated)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 25 , 19 52 , to Aug. 24 , 19 56 , that I last saw the deceased alive on Aug. 24 , 19 56 , and that death occurred at 5:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				DATE SIGNED 8/24/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Aug. 26-56				22b. DATE THEREOF Aug. 26-56			
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff				22d. LOCATION (City, town, or county) (State) Annapolis Md			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				24a. REC'D BY REGISTRAR 8/27/56			
ADDRESS Son Annapolis				24b. REGISTRAR'S SIGNATURE May H. Williams			

CERTIFICATE OF DEATH

NAME OF DECEASED: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF BURIAL: [Faint text]

PLACE OF BURIAL: [Faint text]

NAME OF FUNERAL HOME: [Faint text]

NAME OF MINISTER: [Faint text]

NAME OF CLERGYMAN: [Faint text]

NAME OF CHURCH: [Faint text]

NAME OF CEMETERY: [Faint text]

NAME OF INTERVIEWER: [Faint text]

NAME OF WITNESS: [Faint text]

NAME OF DECEASED'S NEXT OF KIN: [Faint text]

NAME OF DECEASED'S MARRIED NAME: [Faint text]

NAME OF DECEASED'S BIRTH NAME: [Faint text]

RECEIVED
AUG 29 1956
BUREAU V. S.